

6. 2  
142  
17-39  
X32873

State File No. ....

FILED AUG 9 1944

Registration District No. 102

Primary Registration District No. 4174

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Cardwell, Mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: English Clinic  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0 (Specify whether)

In this community 0 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dunklin

(c) City or town 35  
(If outside city or town limits, write "RURAL") 0

(d) Street No. .... (If rural, give location) 0

(e) Citizen of foreign country? .... (Yes or No) 0  
If yes, name country. .... 0

3. (a) PRINT FULL NAME ARTHUR RAY JAMES

3. (b) If veteran, name war. .... No. ....

3. (c) Social Security No. ....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 5, 1944  
year 1944 hour 5 minute 5 P M.

21. I hereby certify that I attended the deceased from 6-5 to 6-5, 1944,  
that I last saw him alive on 6-5, 1944,  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Inf. 11

6. (b) Name of husband or wife. .... 6. (c) Age of husband or wife if alive 5 years (Day) (Year)

7. Birth date of deceased May 5 1940  
(Month) (Day) (Year)

Immediate cause of death Internal Injuries

Due to being run over by a car

Due to .....

Other conditions (Include pregnancy within 3 months of death) 170°

8. AGE: 4 Years 1 Months 0 Days If less than one day  
hr. min.

9. Birthplace Mo (City, town, or county) (State or foreign country)

10. Usual occupation .....

Major findings: Of operations 170°

Of autopsy .....

PHYSICIAN  
Underline the cause to which death should be charged statistically.

11. Industry or business .....

12. Name Walter James

13. Birthplace Mo (City, town, or county) (State or foreign country)

14. Maiden name Belilah King

15. Birthplace Mo (City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident 136

(b) Date of occurrence 6-5-44

(c) Where did injury occur? near Monette, Dunklin Co, Ark  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
At home on the farm  
(Specify type of place)

while at work? t. (e) Means of injury

23. Signature W W Wright M.D. (M-D. or other)  
Address Cardwell, Mo Date signed 6-6-44

16. (a) Informant regular nurse

(b) Address Leachville Rt. 1, Ark

17. (a) Removal (b) Date thereof 6-6-44  
(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director Gregg Ward

(b) Address Monette, Ark

19. (a) July 20 - 44 (b) M G Moore  
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 844-1045

Date Filed 8-4-44

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

.....working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

Registration District No. 102 Primary Registration District No. 4174

1. PLACE OF DEATH:  
(a) County Dunklin  
(b) City or town Cardswell  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

3. (a) PRINT FULL NAME Arthur R. James  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 5  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased May 5 (Month) (Day) (Year)

8. AGE: Years 4 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo.

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) July 20-48 (b) J. J. Moore  
(Date received by Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Dunklin  
(c) City or town Cardswell Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month June 1948 Day 15 Minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

PHYSICIAN  
\_\_\_\_\_  
Underline the cause to which death should be charged statistically.

24574